

Physicians'

new letter

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MSP WEB NEWS

New E-mail Notification Service for MSP Publications

MSP now offers an e-mail notification service for physicians and other health professionals who may wish to be notified of new publications posted to the MSP web site.

Subscribers to this e-mail list receive notice of the following publications

- MSP Physicians' Newsletter
- MSCommunique
- Clinical Practice Guidelines

We encourage you to take advantage of this new service. The e-mail notification list is not used for any other purpose. Only your e-mail ID is required.

To subscribe to this service:

1. Go to <http://www.healthservices.gov.bc.ca/msp/listserv/index.html>
2. Click on the radio button for "subscribe"
3. Enter your complete e-mail address in the box provided
4. Submit your request

At any time you can unsubscribe, or re-subscribe if you change your email ID.

Questions? Please contact:

l_msp_physnews-owner@lists.gov.bc.ca

Chronic Disease Management (CDM) Secure Web site for Practitioners

The Ministry of Health Services is pleased to announce a new CDM secure web site for practitioners. This site was developed as a tool to help physicians manage patients with complex diseases, like diabetes and congestive heart failure. Physicians have been asking for tools to help them monitor the care provided to their patients with chronic conditions. This secure web site has been designed to support this request.

What is the CDM secure site?

It is a means of exchanging confidential information safely, similar to internet banking.

Who can access this service?

If you are a licensed B.C. physician registered with the Medical Services Plan you can request access to the secure web site. Please send an e-mail to: hlth.hnetconnection@gems1.gov.bc.ca. Include the word "reg4614" in the subject line. You will receive an automatic e-mail response with a link to the application form and instructions for completing it. Information on the CDM secure site can be found at:

<http://www.healthservices.gov.bc.ca/cdm/reqaccess.html>

How confidential is the information in this site?

The reports available through the CDM secure site can only be accessed by the physician who "owns" that

information and who is registered with the site to access the information.

What information is available?

The system currently offers the following information for Diabetes and Congestive Heart Failure.

1. Patient Registers (2000/2001 and 2001/02)*

Each doctor can obtain a list of his/her patients who have been identified from administrative data as having diabetes or congestive heart failure. The information is derived from MSP fee-for-service billings and hospital abstracts.

The register is estimated to be 90% accurate and is useful for developing a more accurate register in the doctor's office. Registers include patients identified up to January 2003. Any corrections to a register should be e-mailed to Dr Howard Platt at: hlth.teleplan@gems1.gov.bc.ca

2. Performance Indicators (2000/2001 and 2001/02)*

Each doctor can obtain a performance report indicating the numbers and proportion of his/her patients receiving care according to current guidelines.

Please note that the 2001/2002 performance indicators for Congestive Heart Failure (CHF) are not yet completed.

*For these reports, a patient is allocated to the physician who provided the greatest number of services to the patient in the fiscal year.

Explanatory Codes

The following explanatory codes have been reworded:

- *1 Date of service is prior to coverage effective date.
- KM Paid according to the supportive care formula stated in preamble B.4 e.v) of the MSC Payment Schedule for the date of service of the claim.
- X2 Facility number is missing or invalid.
- X3 Sub-facility number is missing or invalid.

COVERAGE ENQUIRY

All coverage enquiries are now handled electronically by a toll-free automated service. If you need to speak to a client service representative you can contact them through the Victoria number only.

Toll Free	1-800-742-6165
Victoria	250-383-1226
Vancouver	604-669-6667

Use the Practitioner Information Line

The Interactive Voice Response (IVR) service provides coverage information any time of the day or night. Through this service you can:

- Check the date of patient's last eye examination
- Check patient's initials/surname
- Confirm coverage for date of service
- Verify responsibility for subsidy insured service
- Transfer to Info-by-Fax

Please note: Requests for patient coverage information require a Personal Health Number (PHN).

Patient Information

MSP recognizes that obtaining accurate patient information to submit a claim can sometimes be difficult. The following suggestions may be helpful.

Obtain Patient Information prior to a visit

- When your patients call for an appointment ask for their name and PHN exactly as it appears on their CareCard.
- Ask your patients to make sure they bring their CareCard with them to the appointment.
- Ask your patients if they have made changes to their name or coverage since their last visit.

Confirm Patient Information at the time of the visit

Teleplan's Immediate On Line Eligibility function provides coverage information while the patient is at your office. This service allows you to:

- Check coverage for up to 40 patients at one time
- Verify coverage for the current date plus the previous six months
- Learn if a patient is restricted to one physician
- Check when your patient had their last eye examination
- Check if subsidy insured service is paid by MSP or patient

Confirm Patient Coverage prior to the visit

Teleplan's Batch Eligibility function provides overnight verification of patient eligibility. There is no limit to the number of verification requests and the information is available the next morning. As your requests are processed overnight this allows you to submit your next day's or week's roster of patients.

Please note: You are no longer able to access staff through automated services.

General Practitioner

The Medical Services Commission audited a physician's practice as a result of on going screening of practitioner profile statistics. The physician's profiles showed that the use of counseling visit (00120) and complete physical exam (00101) fee items were significantly higher than the average practitioner.

The audit confirmed issues regarding the inappropriate billings of these fee items. In particular, fee item 00120 had been billed for services that were billable only as office visits, as the advice provided was considered a normal component of an office visit.

The practitioner has agreed to repay the Commission \$57,000 for the inappropriate billings, inclusive of the audit costs, and to abide by an appropriate pattern of practice directive. The Commission will continue to monitor the physician's practice to ensure compliance with the Order.

Otolaryngologist

This specialist's practice was chosen for audit as a result of a complaint regarding the performance of an audiometric test when it was neither requested by the referring practitioner nor medically necessary.

The audit verified that billings for fee item 02511 (consultation with pure tone audiogram) and fee item 02521 (speech audiogram) had exceeded the statistical exception limits. The audit showed that the practitioner, was in effect, screening the patients for hearing impairment rather than rendering audiometric tests on referral or on the basis of clinical findings or complaints.

Following negotiation, the practitioner agreed to repay the Commission \$45,000 for the inappropriate billings. The practitioner also agreed to abide by a pattern of practice order that will be monitored by the Commission.

General Practitioner

A review of Emergency billings and the appropriate level at which they are billed led to the audit of a practitioner. Issues discovered in the audit included Level I, II and III billings that did not meet the complexity criteria for the respective emergency care fee item as outlined in the MSP Payment Schedule (Preamble 4-f).

The practitioner has agreed to repay the Commission a total of \$16,000 for the inappropriate billings, inclusive of the surcharge, interest and the cost of the audit and inspection. The practitioner also agreed to abide by a pattern of practice order in which fee items billed must meet the criteria set out in the MSP Payment Schedule.

The Commission will continue to monitor the physician's practice to ensure compliance with the Order.

General Practitioner

A practitioner profile review that showed high rate-based indicators for counselling visits (00120), emergency fee items and referred diagnostic services, especially radiology and laboratory medicine, led to the audit of a practitioner.

The audit showed issues regarding the medical necessity, the accuracy of the billings and a high frequency of counselling visits and emergency visits. In some cases, there was no evidence to support the billed fee.

items in the practitioner's clinical records. The practitioner has agreed to repay the Commission \$16,500 inclusive of audit costs and to abide by an appropriate pattern of practice in which he must adequately record clinical details substantiating the necessity for immediate care.

General Practitioner

A Service Verification Audit Report that showed irregularities led to the audit of a general practitioner. Issues included the correct use of fee item 00112 (emergency visit), billing fee item 00125 (on call/on site weekend hospital visit) only when physically located at the hospital or in the emergency department and the correct use of fee item 13611 (minor laceration /foreign body requiring anesthesia) and the accompanying tray fee 00090.

The practitioner has agreed to repay the Commission \$35,000, inclusive of surcharge, interest and audit costs, for the inappropriate billings. The practitioner has also agreed to abide by a pattern of practice order that requires billing of these fee items only when the criteria are met. The Commission will monitor the physician's practice to ensure compliance with the Order.

General Practitioner

The MSC recently arrived at a settlement agreement with a general practitioner in a dispute about patterns of practice and billing.

At issue were the following:

- Evidence that a portion of the physician's claims for group counselling (fee item 00121) occurred once for each member of a group. The Payment Schedule allows only one claim for the entire group.
- Evidence that a portion of the physician's claims for group counselling occurred when there were accompanying family members who did not seek medical attention and only one person could be identified from the records as a "patient".
- Evidence that the physician billed group counselling fees routinely after reaching the annual maximum of 4 paid claims for fee item 00120 (individual counselling).
- In a significant portion of claims the physician routinely billed fee item 00120 for taking patient histories, followed by claims for a complete physical on a subsequent visit.
- A portion of the fee item 00120 services were claimed when visits were neither prolonged nor difficult.

As a result of a negotiated settlement the practitioner agreed to make restitution in the amount of \$126,669 inclusive of audit costs, surcharge and interest charges. A pattern of practice order directive was agreed to in which the practitioner will bill for these higher value fee items only when the service complies with the payment schedule requirements under Preamble section B-4c.



BCPharmaCare

Fair PharmaCare Registrations Underway

In February 2003, the Honourable Colin Hansen announced that PharmaCare is being modernized to provide fair access to prescription drug users across the province. **BC's new Fair PharmaCare program starts May 1, 2003.**

In order to receive their maximum financial assistance under Fair PharmaCare, British Columbians should register now.

The quickest way to register is using the Web site application process at www.gov.bc.ca or by phoning toll free to 1-800-387-4977. After two weeks, Fair PharmaCare has received more than 15,000 registrations over the Internet and 25,000 through the call center.

Operators are available to take calls in English, Cantonese, Mandarin and Punjabi from 8 am to 10 pm, 7 days a week. Callers are encouraged to call in the evenings and on weekends for faster service.

Mail-in registration forms are also available from pharmacies and doctors' offices, but please be advised that mailed forms will take between 6 and 8 weeks to process.

New CDM List Server

The Ministry is hosting a new list server for those interested in improving chronic care management. The main purpose of the list is to provide a means for the doctors and others participating in the Congestive Heart Failure (CHF) Collaborative to exchange experiences over the next eighteen months. The CHF collaborative is being organized by a steering committee led by the Healthy Heart Society. Doctors interested in participating in the collaborative may request further information from Liza Kallstrom at lkallstrom@healthyheart.bc.ca.

A secondary purpose of the list server is to create a venue for communication among the many individuals and groups in British Columbia interested in improving chronic care management, and implementing the Chronic Care Model.

Those wishing to subscribe to the list should send an email to hltm.cdm@gems1.gov.bc.ca.

A simplified web page for subscription requests is under development and will be accessible from the Ministry's Chronic Disease Management web page.

<http://www.healthservices.gov.bc.ca/cdm>.

New Diagnostic Facility Assignment Form

Effective April 1, 2003, the maximum time limit for all diagnostic facility assignments has been reduced from three to two years. Diagnostic Facility Assignment forms submitted after April 1, 2003, or with an effective date of April 1, 2003 will automatically have the term adjusted from 3 to 2 years.

The new two-sided Diagnostic Facility Assignment form is available through Info by Fax at 250 356-9605.

A copy of the New Diagnostic Facility Assignment form is included in this newsletter.

REMINDER



Correct Submission Codes for Billing Overage Claims

The allowable time for claim submission after a service has been provided is 90 days.

The following exceptions to the 90 day limit are permitted but you must submit claims using the correct submission code:

Submission Code C – Coverage reinstated

- No need to write for prior approval
- Use Submission Code C
- Note record required (coverage reinstated)

Submission Code X – Disagreed with adjudication of your claim

- No need to write for prior approval
- Use submission code X
- Include additional new information required to re-adjudicate claim
- Resubmit within 90 days from the remittance date of the original claim

Submission Code I - Claim has been refused or accepted by ICBC

- No need to write for prior approval
- Use submission code I

- Claims must be resubmitted within 90 days of ICBC decision

Submission Code W – Claim has been refused or accepted by WCB

- No need to write for prior approval
- Use submission code W
- Claim must be submitted within 90 days of being advised of the WCB decision

Submission Code A – Other Circumstances

- Consideration will be given on a case to case basis
- Written request required
- Requests must include detailed explanation for late submission
- Requests must include the date range of the claims, number of claims and the fee items involved
- Administrative issues such as staffing problems, clerical errors, lost or forgotten claims, system or service bureau problems do not qualify for exemption

Requests concerning outstanding claims must be made within 90 days of the day of processing. Research is not provided for stale-dated claims.

Approvals apply only to the exemptions to the 90 day submission limit and do not guarantee payment. All claims billed are still subject to the usual processing and adjudication rules and regulations.

New Primary Health Care Web Site!

<http://www.healthplanning.gov.bc.ca/phc/index.html>

The Ministries of Health Services and Health Planning are pleased to announce a new Primary Health Care (PHC) web site that will be of particular interest to B.C. health-care practitioners and their patients. The site provides an overview of the initiatives underway to renew primary health care and describes how activities are supported through funding from Health Canada's Primary Health Care Transition Fund.

Practitioners and patients will have access to information about the Primary Health Care Transition Fund in B.C., innovative primary health care activities and programs, an overview of various practice models, and contacts and links for other programs such as BC HealthGuide, Chronic Disease Management and Preventative Health.

The PHC web site is expected to expand over the next year. Health authorities, physicians, nurses, other health care practitioners and patients are welcome to provide feedback via the link on the web site to further the development of this exciting new resource.

Additional Acronyms:

CME	Continuing Medical Education
FFS	Fee for Service
JC	Joint Standing Committee on Rural Issues
MAC	Medical Advisory Committee

MOHS	Ministry of Health Services
NIA	Northern Isolation Allowance
RMAC	Regional Medical Advisory Committee
RSA	Subsidiary Agreement for Physicians in Rural Practice

RURAL PHYSICIAN PROGRAMS

The Joint Standing Committee on Rural Issues (JSC), a BCMA/MOHS committee re-established under the new Subsidiary Agreement for Physicians in Rural Practice (RSA) has established eligibility criteria and policies for the \$58.5 million in rural physician programs under the RSA. The programs are designed to enhance the availability and stability of physician services in smaller urban, rural and remote areas of British Columbia. Membership on the JSC includes physicians from five rural communities and five Ministry representatives including two members from rural health authorities.

Information about the programs has been disseminated to physicians over the past few months via letters, news releases and a Rural Programs 02/04 Guide. The new Agreement and information concerning the rural programs can be viewed on the Ministry of Health Services website at <http://www.healthservices.gov.bc.ca/rural/>. For more information on these programs please call the Ministry of Health Services, Rural Health Office at 250-952-5588.

Rural Retention Program (RRP)

The Rural Retention Program (RRP) replaced the Northern Isolation Allowance (NIA) in January 2003. The program provides eligible physicians with fee for service and flat sum premiums from a \$45.4 million annual budget. To determine eligibility for the fee premium, the JSC has approved a medical isolation point assessment system similar to that used by the former NIA program, which recognizes factors that impact the retention of rural physicians, such as medical isolation and community size.

Physicians who reside and practice in communities that qualify for the RRP may be eligible for other RSA programs as well. If a community does not qualify for RRP, the physicians in that community will not be able to access the other rural programs, with the exception of the Northern Isolation Travel Assistance Outreach Program (NITAOP). Please see the enclosed list of eligible RRP communities, retention fee premiums and service clarification codes.

Fee premiums

The level of payment for the rural retention fee premium is based on the location of service in an eligible rural retention community rather than on the community where the physician resides. Resident physicians, itinerant physicians and locum physicians are eligible for the fee premium under the RRP.

The correct code must be entered in the service clarification code field on each fee for service claim and applies to all fee for service claims with a service date starting January 1, 2003. If you have submitted and received payment for claims without the RRP code or submitted claims with an incorrect RRP code, please indicate the correct code and resubmit the claims. An enhancement has been made to the fee for service adjudication program to accept the rebilling and generate a reversal of the original billing. If you have any questions regarding the rebilling please contact Teleplan Support in Victoria at 952-2664 or 1-800-663-7206 for the rest of B.C.

Flat sums

The flat sums for January 1, 2003 to March 31, 2003 were calculated by the program area in the Ministry and distributed to Health Authorities on February 28, 2003 for payment to local physicians. Flat sums for 2003/2004 fiscal will be distributed to health authorities on a semi-monthly basis. Physicians must meet residency and income criteria to be eligible for the flat sum fee, and are entitled to retroactive flat sums after the residency requirement is completed. Health authorities must notify the Ministry of the successful completion of the residency period.

Geographic Differential Payment Rate (GDPR)

The Geographic Differential Payment Rate for Psychiatry is to be discontinued, and Psychiatry will be incorporated into RRP as of April 1, 2003, as per a decision by the Psychiatry Section. The Tariff Committee has approved a 0.7% across the board fee increase for Psychiatry to repatriate funds used for the GDPR. Psychiatrists must use the appropriate service clarification codes for their fee for service (FFS) billings for services provided April 1, 2003 and onwards.

Rural Continuing Medical Education (RCME)

The Rural Continuing Medical Education program provides funding for medical education activities to support the maintenance of those skills needed for rural practice. The program, which replaces the enhanced CME effective January 1, 2003, provides from \$400 to \$5,200 annually for physicians in eligible rural communities, based on community medical isolation points and duration of practice. Health authorities will distribute RCME funds to physicians.

Rural Education Action Plan (REAP)

The Joint Standing Committee on Rural Issues expanded the Rural Education Action Plan with additional funds provided under the RSA. Rural physicians interested in the Advanced Skills and Training Programs or the First Year Practice Enhancement, or in participating in the undergraduate medical student program can contact the Educational Coordinator at the Undergraduate Teaching Office, Department of Family Medicine at 604-875-5602.

Two specialty-training bursaries of \$25,000 per annum are available to assist residents in funded positions in the last two years of their training. Recipients must guarantee a year of service in an RSA community for each year of bursary they receive. For information contact Rural Health, Ministry of Health Services at 250-952-3588.

Rural GP Locum Program (RGPLP)

The Northern and Rural Locum Program has been renamed the Rural GP Locum Program and provides a travel honorarium of \$600 and a guaranteed daily rate of \$750 for the provision of locum services in eligible communities. The program provides up to 28 days per year per physician for locum relief for GPs in rural communities with seven or less physicians. Each GP locum assignment must be at least 5 days in duration. Please contact Provider Programs at 250-952-2654 if you are interested in providing locum services or obtaining locum relief.

Northern Isolation Travel Assistance Outreach Program (NITAOP)

The Northern Isolation Travel Assistance Outreach Program (NITAOP) continues to provide funding for approved physicians who visit rural and isolated communities to provide medical services. With additional funds provided for the program under the RSA, the JSC increased the travel honorarium to a maximum of \$1,000 per return trip, effective January 1, 2003. Physicians visiting eligible

communities receive assistance for a maximum of 24 visits per community for each approved specialty per year, where the requested specialty is not available within a 1.5 hour drive (105 km). Each Health Authority submits annual requests to the NITAOP program at the Rural Health office, which administers the program. If you have any questions or concerns regarding your NITAOP payments contact Provider Programs at (250) 952-2654.

RECRUITMENT

Recruitment incentives are available to physicians recruited to fill vacancies or pending vacancies that are part of Health Authority Physician Supply Plans, which are developed with input from the local MAC or RMAC. The program provides \$10,000 to each eligible full-time physician recruited to fill a vacancy in an RSA community, if recruited from a community *not* covered by the RSA.

The Recruitment Contingency Fund provides funding to assist health authorities or physician groups experiencing severe difficulty in filling vacancies and where the inability to fill the vacancy in a timely manner is expected to negatively impact the delivery of care. The Health Authority must submit requests to the JSC for consideration, and physician groups should contact their health authority for more information on this fund.

Rural Specialist Locum Program (RSLP)

In addition to the programs funded under the RSA, the Ministry of Health Services has provided \$1 million for the term of March 1, 2003 to February 29, 2004 for an interim Rural Specialist Locum Program. The program will help rural specialists secure subsidized periods of leave from their practices for purposes such as CME or vacation and will assist in the provision of 24/7 emergency on call availability as required by the health authority. The program is available for core specialties in Campbell River, Comox/Courtenay, Cranbrook, Dawson Creek, Fort St. John, Nelson, Port Alberni, Powell River, Prince George, Prince Rupert/Kutai, Smithers, Quesnel, Terrace, Trail and Williams Lake. Designated core specialties are anesthesia, general surgery, internal medicine, orthopedics, pediatrics and obstetrics. To be eligible for the RSLP, there must be less than five specialists practicing in the designated specialty.

A Call to Physicians to Participate in Province-Wide Congestive Heart Disease Collaborative

The Collaborative on Congestive Heart Failure (CHF) is pleased to offer B.C. family physicians the opportunity to participate in an exciting and innovative project aimed at improving the management of patients with chronic diseases.

What is the CHF Collaborative?

The CHF Collaborative, the first of its kind in B.C., is a province-wide initiative designed to assist practitioners in introducing effective disease management strategies in their practices with the overall goal of maximizing the length and the quality of life for their patients. The Collaborative is a cooperative project of the Healthy Heart Society, Health Authorities and Ministries of Health Planning and Health Services.

How Does the Collaborative Work?

The Collaborative takes place over a 12-month period. Using a learning program developed by the highly successful Institute for Health Care Improvement (<http://www.ihc.org/collaboratives>), clinical practice teams attend three interactive two-day learning sessions on the components of good chronic disease management and methods for integrating the components into their clinical practice. Additionally, the teams learn methods for measuring the impact of these practice changes on their patients' health outcomes.

During an "action period" between the learning sessions, the teams try out the strategies they have learned, assess what changes worked, and report on their progress and challenges with fellow learners. Expert advice, reports on progress made, and lessons learned are shared through conference calls and a web-based list server where ideas and experiences can be exchanged.

What is a CHF Clinical Practice Team?

- The Clinical Practice Teams consist of primary care physicians, internists, cardiologists, registered nurses and other key office staff who will work together for at least 12 months to implement chronic illness population management for patients with CHF. Funding support for the learning sessions is available through your Health Authority.

How do I become involved?

All that is required to become involved is to organize a clinical practice team that is committed to:

- attending all three of the Learning Sessions;
- implementing and testing changes in chronic care delivery; and
- sharing what they have learned with other practice teams.

The first learning session is scheduled for Monday May 26 and Tuesday May 27.

What are the advantages of participating in the CHF Collaborative?

Physicians and other health professionals that participate in the Collaborative can expect to see improved health outcomes for their patients and greater satisfaction, both professionally and personally with their practice. As well as learning how to implement office infrastructures that help proactively manage certain groups of patients, physicians can expect to see improved office efficiency through better care planning, team development, and more effective patient management.

But mostly, your patients will benefit from your participation. CHF is the primary cause of death for British Columbians, and the leading reason for hospitalization among people 65 years and older. The Collaborative will help you maximize your patients' health outcomes and quality of life.

For more information or to find out how to participate in the CHF Collaborative, contact Liza Kallstrom, Healthy Heart Society of BC at 604 742-1772 or email: lkallstrom@healthyheart.bc.ca.

One Medical School – Three Sites

The University of British Columbia Faculty of Medicine is expanding through an innovative, distributed medical education program in partnership with the Government of British Columbia, the University of Northern British Columbia (UNBC), the University of Victoria (UVic) and provincial regional health authorities.

The first of its kind in Canada, the program will double B.C.'s undergraduate class sizes over a period of 10 years through the Island Medical Program (IMP), the Northern Medical Program (NMP) and the Vancouver-Fraser Medical Program (VFMP). New academic facilities with state-of-the-art technology are under construction at all three universities to accommodate the influx of students.

Identifying and recruiting B.C. physicians interested in becoming community-based teachers will be an important component of the expansion program.

During the initial phase of expansion, 24 students will be admitted to each of the three programs in 2004.

Students will spend the first four months in Vancouver and the remainder of their first two years in the IMP, NMP or VFMP. The clinically-based third and fourth years of the program will provide a range of enriching, community-oriented educational experiences through the medical school's province-wide network of affiliated teaching hospitals and health authorities.

All students must meet UBC's well-established medical school performances standards in order to graduate with a UBC medical degree.

For more information on the medical school expansion visit our website at www.med.ubc.ca. For more information on becoming a community-based clinical teacher contact Dr. Peter Kirk, Clinical Coordinator, IMP clincoor@uvic.ca; Dr. David Rutledge, Clinical Coordinator, NMP rutledge@unbc.ca; or Lua Lynch, Site Coordinator, VFMP llynch@medd.med.ubc.ca.

New Medical Imaging Requisition Forms

The Medical Services Commission has approved two new out-patient requisition forms submitted by the BCMA/MSP Working Committee to Review Standard Outpatient Requisition Forms.

1. The *Standard Out-Patient Bone Densitometry Requisition*

The intent of this form is to assist physicians in the compliance of the Bone Densitometry Protocol.

2. The *Standard Out-Patient Breast Imaging Requisition*

The intent is to improve clinical information required to perform the test and to reduce the time frame for possible further studies.

All medical imaging facilities providing the above services should introduce these forms by August 3, 2003. Audit recoveries related to non-compliance with the approved standard requisition form are effective October 1, 2003.

Copies of the new requisition forms are included with this newsletter.

COUNSELLING VISITS

As a result of MSP audits, a number of areas of inappropriate billing practices have been identified. Practitioners should ensure they are aware of the billing requirements related to these issues and that billings are in compliance with the *MSC Payment Schedule* and the *Medical and Health Care Services Regulation*.

Counselling Visits

Preamble B-4-c states that counselling is to be claimed only when the problem is *difficult* and the physician's intervention must of necessity be over and above the advice which would normally be appropriate for that condition, *or* the patient is experiencing *significant* emotional distress. The preamble goes on to state:

Counselling is not to be claimed for advice that is the normal component of any visit or as a substitute for the usual patient examination fee, whether or not the visit is prolonged. For example, counselling fees must not be used simply because the assessment and/or treatment may take 20 minutes or longer, such as in the case of multiple complaints.

There is a matter of professional judgment to be applied to the terms "difficult" and "significant". The normal anxiety that accompanies a visit to the physician is adaptive. Maladaptive anxiety, grief or other distress may justify the billing of counselling. Audit inspectors look for evidence that the patient is having difficulty coping. Such evidence may include the following: changes in job performance, personal hygiene or grooming; anhedonia, sleep disturbance, appetite disturbance, relationship breakdown, and feelings of despair or hopelessness.

The Preamble gives only one example of a "difficult" medical condition, citing the patient newly diagnosed with juvenile diabetes. Audit inspectors will seek information in the patient records to substantiate the difficult nature of the problem. It is important that a complete and legible record exists to support the claim for counselling.

Patient Complexity

We are aware that some physicians have adopted a "one problem, one visit" policy. Patients are generally unhappy with this approach. In addition it is not supported by the policies the Medical Services Commission indicated in Preamble B 4. In audit, the frequency of patient visits, if unusual for the complexity of the patient, requires justification.

Our inspectors – who are practicing physicians – are trained to give the benefit of the doubt to the auditee in uncertain cases, but to look for justification to support billing. While it is often very reasonable to schedule several visits when dealing with patient complexity, physicians should recognize that the fees are intended to reflect the average complexity of visits. Especially now that visit fees are age adjusted, one must recognize that not all complex and ill patients are old, and not all old patients are sick and complex. Thus the fees reflect the increasing likelihood of complexity at an advancing age. To insist on a single visit per problem is to defeat the underlying premise of average prices per visit. Furthermore, good care requires attention to the entire patient (the whole) and not simply problems (the parts). Please note the following selection of Preamble section B 1, which states, in part:

All benefits listed in the MSC Payment Schedule, except where specific exceptions are identified, must include the following as inherent in the service being claimed and payment for these inherent components is included in the listed fees.

- a. Direct face-to-face encounter with the patient by the physician or delegate, appropriate physical examination when pertinent to the service and on-going monitoring of the patient's condition during the encounter, where indicated.
- b. Any enquiry of the patient or other source, including review of medical records, necessary to arrive at an opinion as to the nature and/or history of the patient's condition.

- c. *Appropriate care for the patient's condition, as specifically listed in the Schedule for the service and as traditionally and/or historically expected for the service rendered.*
- d. Arranging for any related assessments, procedures and/or therapy as may be appropriate and interpreting the results, except where separate listings are applicable to these adjunctive services. (Note: this does not preclude physicians rendering referred "diagnostic facility" services from billing for interpretation of diagnostic test results.)
- e. Arranging for any follow-up care which may be appropriate.
- f. *Discussion with and providing advice and information to the patient or the patient's representative(s) regarding the patient's condition and recommended therapy, including advice as to the results of any related assessments, procedures and/or therapy which may have been arranged. No additional claims may be made to the plan for such advice and discussion, nor for the provision of prescriptions and/or laboratory requisitions, unless the patient's medical condition indicates that the patient should be seen and assessed again by the physician in order to receive such advice.*
- g. *Making and maintaining an adequate medical record of the encounter, which appropriately supports the service being claimed. A service for which an adequate medical record has not been recorded and retained is considered not to be complete and is not a benefit under the Plan.*

The above excerpts (**in italics**) support an underlying philosophy that the Payment Schedule is not to be manipulated to unnecessarily fragment or "unbundle" patients' care.

Standing Orders for Diagnostic Testing – Amendment to CMQ96-012

The use of standing orders for diagnostic tests pertaining to a specific patient over a specific period of time is acceptable. Unless stated otherwise by the referring physician, standard orders automatically expire after 12 months. The default expiry date of 12 months will be changed from 6 months, effective June 1, 2005.

Because it is inappropriate to order tests for "life" or other such terms, a two-year limit has now been placed on the period that a physician may specify for a standing order.

Standing orders pertaining to routine diagnostic requests by physicians, for all patients are not acceptable. A physician cannot request to have a routine menu of laboratory tests performed or a routine set of additional views taken when X-rays are ordered. For example, weight-bearing views and patellar views cannot be performed routinely when a knee x-ray is requested.

In accordance with the above policy, the diagnostic facility is responsible for ensuring that documentation is consistent with and supports the claim(s) submitted. In the case of an audit, any claim for which the documentation cannot be provided to MSP will be recoverable pursuant to section 25 of the *Medicare Protection Act*.

Specialist Hospital Coverage – Consultations

When one specialist provides coverage for another during a patient's hospital stay (e.g. weekend coverage), a consultation should not normally be charged for the first time the patient is seen unless the specialist has been referred specifically for the purpose of providing a medically required consultation. Preamble B.5 of the Medical Services Commission *Payment Schedule* describes the circumstances under which a consultation may be billed to the Medical Services Plan. Routine hospital visits performed by the physician providing coverage should be billed under the appropriate referred specialist hospital visit fee (e.g. fee item 00508 for Internal Medicine).

Restricted Claimants Program

PharmaCare's Restricted Claimants Program has been in place since the 1970s. It restricts payment of prescription drugs for patients who appear to have difficulty managing their prescription drugs.

The program works this way:

The patient's PharmaCare drug coverage is restricted to one pharmacy and one doctor (plus specialists).

If the patient fills a prescription at a different pharmacy or if a different doctor has written the prescription, PharmaCare will not cover the cost of the prescription.

The pharmacist, as always, applies professional judgment in determining whether or not to fill the prescription.

In emergency circumstances, PharmaCare will make one-day changes to the doctor or pharmacy restriction. Exceptions are made only if the patient is unable to see their own doctor or get to their own pharmacy and if not filling the prescription could result in serious harm to the patient.

PharmaCare Coverage of Early Fills of Medications

On November 28, 2002, PharmaCare introduced a system enhancement to ensure prescriptions for long-term medications are not filled too soon.

The enhancement helps to eliminate the dangers associated with having excess quantities of medication on hand. It also avoids wastage, especially in cases in which a medication is discontinued while the patient still has a large supply on hand. In such cases, the drug and any portion of the cost paid by the patient and by PharmaCare are wasted.

Here is how the computer enhancement works. If a patient submits a new prescription for a medication they were previously prescribed or if a patient requests a refill of a medication, when the pharmacist enters the claim on the computer, the system checks to see if the previous fill occurred within 60 days of the current date.

If the previous fill did occur less than 60 days earlier, the system then looks at the days' supply that the pharmacist entered for the fill.

If the result indicates that that patient has more than 14 days' supply of medication left, the system automatically adjudicates the new claim as "PharmaCare to pay zero." If the patient chooses, they may still have the prescription filled or refilled, but PharmaCare will not cover any portion of the cost.

To have PharmaCare cover the eligible costs of the fill, the patient should return to the pharmacy when they have less than 14 days' medication on hand.

Note: In some cases, after consultation with the pharmacist and perhaps with the physician, it may be determined that an early fill of a prescription is appropriate. In this case, PharmaCare would cover the eligible costs.

Subscription Service Now Available

An e-mail subscription service is available for pharmacies, physicians and stakeholders who would like to be notified when a new PharmaCare Newsletter or PharmaNet Bulletin is posted on the PharmaCare Web site.

To subscribe, visit the PharmaCare Web Site at: www.healthservices.gov.bc.ca/pharmc.

No Charge Permitted for Special Authority Form

At its March 2003 meeting, the Medical Services Commission confirmed that completion of the Pharmacare Special Authority Form (SAF) is considered part of the regular office visit, a MSP benefit. Thus, MSP payment for the visit includes completion of the SAF when required. Practitioners may not otherwise bill the Plan, the patient, or anyone else for completion of the SAF. Any patient charge would be considered "extra billing" contrary to the *Medicare Protection Act*.

Drugs under Review

The following drug submissions are currently under review by the Drug Benefit Committee of PharmCare:

anakinra (KINERET®)	mometasone furoate (AZMAX Twisthaler®), resubmission
ancestim (STEMGEN®)	olanzapine (ZYPREXA®) new strength
alfuzosin (XATRAL®)	peginterferon alfa-2b + ribavirin (PEGETRON®)
bimatoprost 0.03 % ophth soln, (LUMIGAN®)	perindopril/indapamide (BIPREL®)
botulinum toxin (BOTOX®), new indication	repaglinide (GLUCONORM®), resubmission
clopidogrel (PLAVIX®) new indication	rivastigmine (EXELON®), resubmission
desmopressin tabs (DDAVP), resubmission	rosuvastatin (CRESTOR®)
desmopressin acetate injection (OCTOSTIM®)	tacrolimus ointment (PROTOPIC®)
donepezil (ARICEPT®), resubmission	17-b-estradiol (VAGIFEM®)
eprosartan (TEVETEN®), resubmission	tegaserod hydrogen maleate (ZELNORM®)
filgrastim (NEUPOGEN®), new indication	testosterone USP (ANDRODERM®)
fondaparinux sodium (ARIXTRA®)	tiotropium/verapamil hydrochloride SR (SPIRIVA®)
glimepiride (AMARYL®)	trandolopril (MAVIK®), resubmission
irbesartan (AVAPRO®) new indication	trandolapril/verapamil hydrochloride SR (TARKA®)
valdecoxib (BEXTRA®)	

Watch for our Symbols

Articles that may be of particular interest to physicians are marked with this caduceus symbol.



Articles that may be of particular interest to MOAs are marked with this file symbol.

Letter to Practicing Physicians from P. R. W. Kendall, MBBS, MSc, FRCPC, Provincial Health Officer

Re: HIV Infection added to the Health Act Communicable Disease Regulation Schedule A and B

This letter is to inform you that as of April 30, 2005, HIV infection will be added to Schedules A and B of the *Health Act Communicable Disease Regulation* under the *Health Act*.

British Columbia is the most recent province to make HIV reportable, and, as in other provinces where HIV is already reportable, people will have a choice of being tested with or without their name appearing on the test requisition. If a patient decides not to have their name included on the requisition, their initials and date of birth will appear instead.

The main rationale for making HIV reportable in British Columbia is to involve the public health system in the notification of partners of people who have tested positive for HIV. This is a proven procedure for reaching people at high risk of infection. Beginning on May 1, 2005, public health personnel will routinely contact physicians' offices and clinics which offer HIV testing, to assist with or undertake voluntary¹, confidential² contact identification and partner notification for people who have newly tested positive for HIV.

Physicians and other health professionals involved in HIV testing should provide pre-test counselling to patients which addresses the following points:

1. The patient must be made aware that a notification of a positive test result will be sent to the local medical health officer.
2. Patients must be advised that they may select nominal (with name) or non-nominal (initials and birth date) testing and that in either case public health personnel will be involved with the patient's physician in follow-up care and partner notification.
3. Patients must be advised that whichever type of testing they choose, if they test positive for HIV, the local medical health officer or a public health nurse will be contacting the patient's physician to enquire about the patient's ability or willingness to take part in confidential, voluntary partner notification, and to determine how any identified partners of the patient will be notified.
4. Patients should be advised that partner notification, which is confidential and voluntary, has the benefit of allowing persons who are at risk, and may not know it, to learn their status, modify their behaviours, and obtain care much more rapidly than otherwise might be the case.

Physicians and other health professionals, including nurses and laboratory staff, involved in HIV testing, counselling and care and support must be aware that:

- The addition of HIV to Schedules A and B of the *Health Act Communicable Disease Regulation* will attract the confidentiality obligations of section 6.1 of the Regulation. A breach of section 6.1 constitutes an offence by virtue of section 104(1) of the *Health Act*, and could result in a fine of \$200,000 and/or 12 months in jail.
- The names of people who are HIV positive cannot be released outside the public health system without the consent of the patient. People, including providers, who release this information without authorization are liable to the penalties set out in section 104(1) of the *Health Act*.
- The general rule of confidentiality under the *Health Act Communicable Disease Regulation* is that anyone who has information about a patient, as a result of the patient having voluntarily tested for a reportable, communicable disease, must not disclose that information to anyone, except as authorized by the patient, or, in the case of public health officials, as required in the course of their duties under the *Health Act* and the *Health Act Communicable Disease Regulation*.
- The only exception to this rule is that if a physician has reasonable grounds to believe that any third party may be at risk of harm from a patient, that physician may, without the patient's consent, written or otherwise, advise the medical health officer of the physician's concerns. The medical health officer may then gather further information and may, if he or she deems it is warranted, disclose any or all of this information, again without the patient's consent, written or otherwise, to any person who might be at risk of harm. This exception enables physicians to discharge their ethical duty to warn third parties who may be at risk, without running afoul of the confidentiality provisions of the *Health Act Communicable Disease Regulation*.
- A new HIV requisition form has been developed which includes a choice of nominal or non-nominal testing, with a check box for completion which will clearly identify to the laboratory which choice the patient has made.

A full report on HIV reportability may be found at <http://www.healthplanning.gov.bc.ca/phio/other.html>

¹ Voluntary – index patients are encouraged but never coerced into identifying partners whose behaviours (unprotected sexual activity, needle/syringe sharing etc.) may have exposed them to a risk of virus transmission.

² Confidential – in that the index patient's name is not disclosed to contacts who are followed up by public health nurses.


**STANDARD OUT-PATIENT
BONE DENSITOMETRY REQUISITION**

X-RAY FACILITY ADDRESS		X-RAY USE ONLY	
BILLABLE TO: ☐ MSP ☐ ICBC ☐ WCB ☐ PATIENT ☐ OTHER		NAME OF PHYSICIAN & MSP PRACTITIONER NUMBER (or office stamp)	
PERSONAL HEALTH NUMBER	DOB: YYYY / MM / DD		
SURNAME OF PATIENT	FIRST NAME AND MIDDLE INITIAL		
TELEPHONE # (INCLUDE AREA CODE)	GENDER: ☐ M ☐ F PREGNANT: ☐ Yes ☐ No		
ADDRESS	CITY/TOWN	POSTAL CODE	COPY RESULTS TO:

APPOINTMENT DATE	APPOINTMENT TIME
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PERTINENT HISTORY

PREVIOUS BONE DENSITOMETRY ☐ YES ☐ NO	LOCATION	DATE
PREVIOUS LUMBAR SPINE X-RAYS ☐ YES ☐ NO	LOCATION	DATE

EXAMINATION REQUESTED
☐ **DIAGNOSTIC BONE DENSITOMETRY**

Covered by MSP but an indication MUST be checked. Indications are as defined in the Protocol for Bone Density Measurement, Medical Services Commission and BCMA, May 1, 1999.

1. APPROPRIATE INDICATIONS:

- ☐ HYPOGONADISM (OTHER THAN POSTMENOPAUSAL ESTROGEN DEFICIENCY)
- ☐ LONG TERM ORAL GLUCOCORTICOSTEROID THERAPY (OR CUSHING'S SYNDROME)
- ☐ PRIMARY HYPERPARATHYROIDISM
- ☐ A STRONG FAMILY HISTORY OF OSTEOPOROSIS, WHEN THERAPY IS UNDER CONSIDERATION
- ☐ OTHER SITUATIONS WHERE INFORMATION ON BONE DENSITY IS CONSIDERED ESSENTIAL TO DECISIONS ABOUT THERAPY

2. LOW-TRAUMA FRACTURES

- ☐ BASELINE MEASUREMENT

3. PRE-TREATMENT ASSESSMENT:

- ☐ BASELINE MEASUREMENT

4. FOLLOW-UP:

- ☐ PATIENT RECEIVING HIGH DOSE CORTICOSTEROID THERAPY
- ☐ PATIENT RECEIVING OTHER DRUG THERAPY MAY HAVE FOLLOW-UP MEASUREMENTS PERFORMED ANNUALLY FOR THREE CONSECUTIVE YEARS (IF BONE MASS HAS STABILIZED AFTER THREE YEARS, REPEAT MEASUREMENTS MAY BE PERFORMED EVERY TWO YEARS)
- ☐ MORE THAN TWO YEARS SINCE PREVIOUS BONE DENSITY EXAMINATION

ANY INDICATION NOT LISTED ABOVE IS CONSIDERED AS SCREENING

☐ **SCREENING BONE DENSITOMETRY**

This is not an MSP insured service, the patient must pay.

SIGNATURE OF REQUESTING PHYSICIAN

TELEPHONE REQUISITION TIME	INITIALS OF RECORDER	DATE SIGNED (YYYY / MM / DD)
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**STANDARD OUT-PATIENT
BREAST IMAGING REQUISITION**

X-RAY FACILITY ADDRESS		X-RAY USE ONLY	
BILLABLE TO: ☐ MSP ☐ ICBC ☐ WCB ☐ PATIENT ☐ OTHER		NAME OF PHYSICIAN & MSP PRACTITIONER NUMBER (or office stamp)	
PERSONAL HEALTH NUMBER			
DOB: YYYY / MM / DD			
SURNAME OF PATIENT		FIRST NAME AND MIDDLE INITIAL	
TELEPHONE # (INCLUDE AREA CODE)		GENDER ☐ M ☐ F	PREGNANT ☐ Yes ☐ No
ADDRESS		CITY/TOWN	POSTAL CODE
		COPY RESULTS TO:	

☐ **DIAGNOSTIC MAMMOGRAPHY** ☐ **ULTRASOUND**
☐ Proceed to further imaging if indicated (mammography or ultrasound)

☐ Proceed to needle biopsy if indicated and feasible

OR

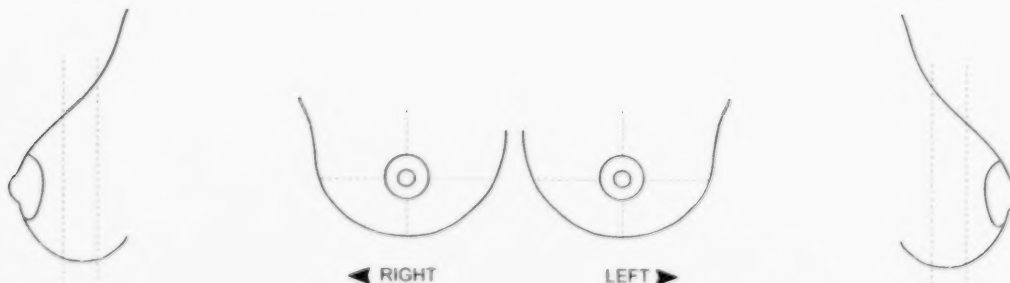
☐ Call me if further investigation is necessary

HISTORY

PREVIOUS MAMMOGRAMS ☐ YES ☐ NO	DATE(S)
PREVIOUS BIOPSIES / SURGERY ☐ YES ☐ NO	DATE(S)
HORMONE THERAPY ☐ YES ☐ NO	DATE(S)
FAMILY HISTORY OF BREAST CANCER ☐ YES ☐ NO	RELATIONSHIP
MENSTRUAL HISTORY LMP (DATE):	
MENOPAUSE (AGE):	

PRESENT COMPLAINT (Please check the appropriate indication)

☐ LUMP	☐ THICKENING	☐ LOCALIZED PAIN/TENDERNESS	☐ NIPPLE DISCHARGE
☐ 'ABNORMAL' SCREENING MAMMOGRAM	☐ FOLLOW UP OF PREVIOUS FINDINGS	☐ PREVIOUS BREAST CANCER	☐ BREAST PROSTHESES (IMPLANTS)
☐ OTHER, SPECIFY:			

PLEASE MARK AREA(S) OF CONCERN WHEN APPROPRIATE


TELEPHONE REQUISITION TIME	INITIALS OF RECORDER	DATE SIGNED (YYYY / MM / DD)
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SIGNATURE OF REQUESTING PHYSICIAN



BRITISH
COLUMBIA

Ministry of Health Services
Medical Services Plan

**ASSIGNMENT OF MSP PAYMENTS
FOR DIAGNOSTIC FACILITY SERVICES
NOTICE TO PRACTITIONERS AND PAYEES**

IMPORTANT – YOU MUST READ BOTH SIDES OF THIS FORM

I, Dr. _____, Practitioner Number _____
Name of Physician - "the Assignor"

hereby assign to _____
Name of Diagnostic Facility - "the Assignee"

Payment #(s) _____, and Facility #(s) _____

all payments owing to me by the Medical Services Commission of British Columbia ("MSP Payments") for the following services (check applicable boxes):

- | | |
|--|---|
| ☐ Radiology | ☐ Pulmonary Function |
| ☐ Ultrasound | ☐ EMG |
| ☐ Polysomnography | ☐ ECG |
| ☐ Laboratory Medicine | ☐ EEG |
| ☐ Nuclear Medicine | ☐ Other: _____ |

This Assignment applies to all claims submitted in the format approved by the Medical Services Commission bearing both my practitioner number, _____, and the Diagnostic Facility's payment #(s) _____:

(i) for the period from _____ to _____ ; or
Month/Day/Year Month/Day/Year

(ii) for the following specific dates _____ ; or

(iii) for a period no greater than (2) years from _____
Month/Day/Year

unless I notify the Commission in writing to cancel this assignment.

I authorize the Commission to direct the MSP payments to any address specified by the Diagnostic Facility from time to time.

I confirm that I have read and understand the Preamble to the Medical Services Commission Payment Schedule on the reverse side of this assignment. I understand that I must comply with the *Medicare Protection Act*, the *Medical and Health Care Services Regulation* and all requirements of the Medical Services Commission Payment Schedule.

I understand that payment by the Commission to the Diagnostic Facility under this Assignment discharges the Commission of any indebtedness for those same accounts to me, and releases the Commission from any indebtedness to me, my executors, my administrators or other assignees for the amounts paid.

Dated this _____ day of _____, 20 _____

Signature of PRACTITIONER

M.D.

Authorized Signature for PAYEE

Signature of WITNESS

Signature of WITNESS

Print Name of Witness

Print Name of Witness

IMPORTANT NOTICE TO PRACTITIONERS AND PAYEES

Preamble 3, Medical Services Commission Payment Schedule –

An **“Assignment of Payment”** is a legal agreement by which an attending physician assigns payment for the services specified in the Assignment to another party. The designated party may use the attending physician’s practitioner number in combination with its own payment number when submitting claims to the Medical Services Plan (MSP). To authorize the MSP to pay a designated party, the attending physician must complete and file an “Assignment of Payment” form. However, even though the payment has been assigned, the responsibility for the delivery of clinical services, and its appropriate billings remains with the physician whose practitioner number is used.

- ♦ To the extent the information submitted to MSP is subsequently found to be untrue, it is the physician who is liable to repay both the technical and professional components of the claims. Claims submitted using the wrong practitioner number or contrary to Billing Rules paragraphs 1 and 2 will be recovered under sections 30 and/or 37 of the *Medicare Protection Act*.

To limit liability –

- ♦ In the case of physicians providing limited or locum coverage the time period indicated on the form must be the same as the time period assigned for the limited or locum coverage.
- ♦ Physicians who have made a two (2) year assignment of payment to a diagnostic facility must advise MSP in writing if he or she ceases to be associated with the diagnostic facility before the assignment expires.

Billing rules –

1. Laboratory Medicine services may be submitted by diagnostic facilities using only one practitioner number. Different practitioner numbers may be used on a rotating basis. A physician and the diagnostic facility should agree on how the practitioner number will be used.
2. ECG, EEG, EMG, Nuclear Medicine, Polysomnography, Pulmonary Function Studies, Radiology and Ultrasound services:

Unless approved in writing to the contrary by MSP, all claims must be submitted under the practitioner number of the physician who actually rendered or interpreted the service for which the claim is made.

Provider Programs
Claims Division
Box 9480
Victoria, BC V8W 9P6
Telephone: 250 952-2654
Fax: 250 952-3101

Rural Retention Program - Premiums and Flat Fee Sums

Effective January 1, 2003

* For communities without a resident physician or vacancy, the total isolation points will be applied as a fee premium, to a maximum of 30 percent."

** Community falls below the minimum isolation points to qualify. Therefore, eligible physicians are entitled to receive 50 percent of the previous year's retention allowance (for January 1 to March 31, 2003 - 50% of PRRP allocation)

COMMUNITY	COMMUNITY SERVICE CLARIFICATION CODE	FEE PREMIUM 30% MAX	ANNUAL FLAT FEE ALLOCATION
100 Mile House	MH	16.10	\$14,076
Agassiz/Harrison	A6	4.20	\$3,672
Ahousat *	A4	26.25	\$0
Alert Bay	A1	23.38	\$20,441
Anahim Lake *	A5	30.00	\$0
Armstrong/ Spallumcheen **	A7	0.00	\$0
Ashcroft	A3	15.65	\$13,688
Atlin *	A2	30.00	\$0
Bamfield *	B8	23.25	\$0
Barriere	B4	11.90	\$10,404
Bella Coola	B3	27.30	\$23,868
Big White	B7	11.90	\$10,404
Blue River *	B5	30.00	\$0
Bowen Island	B6	5.95	\$5,202
Bridge Lake	B1	21.42	\$18,727
Burns Lake	B2	26.18	\$22,889
Campbell River	CR	7.14	\$6,242
Canal Flats *	C5	30.00	\$0
Castlegar	CA	11.34	\$9,914
Chase	CH	9.10	\$7,956
Chetwynd	C2	26.74	\$23,378
Christina Lake/Grand Forks	C7	19.18	\$16,769
Clearwater	C8	18.34	\$16,034
Clinton	C3	15.86	\$13,872
Cortes Island	C4	16.70	\$14,606
Courtenay/Comox/Cumberland	CC	6.93	\$6,059
Cranbrook	CB	12.60	\$11,016
Creston	C6	17.78	\$15,545
Dawson Creek	D1	23.10	\$20,196
Dease Lake	D3	30.00	\$31,375
Denman Island	D2	9.35	\$8,180
Duncan/N. Cowichan	D4	0.00	\$0
Edgewood *	E2	30.00	\$0
Elkford	E1	21.70	\$18,972
Enderby	E3	10.36	\$9,058
Fernie	F1	18.90	\$16,524
Fort Nelson	F2	30.00	\$31,375
Fort St. James	F3	25.62	\$22,399
Fort St. John	F4	27.30	\$23,868
Fraser Lake	F5	25.62	\$22,399

Gabriola Island	G7	5.95	\$5,202
Galiano Island	G5	10.71	\$9,364
Gold Bridge/Bralorne *	G6	23.85	\$0
Gold River	G2	16.49	\$14,423
Golden	G1	20.02	\$17,503
Granisle *	G4	30.00	\$0
Greenwood/Midway/Rock Creek	G3	21.42	\$18,727
Hartley Bay *	H6	30.00	\$0
Hazelton	H1	30.00	\$27,397
Holberg *	H2	30.00	\$0
Hope	H8	8.30	\$7,262
Hornby Island	H5	15.86	\$13,872
Hot Springs Cove *	H7	26.25	\$0
Houston	H4	26.74	\$23,378
Hudson's Hope	H3	30.00	\$29,845
Invermere	VM	21.14	\$18,482
Kaslo	K1	14.42	\$12,607
Keremeos	K8	9.56	\$8,364
Kimberley	KM	12.60	\$11,016
Kincolith *	KK	30.00	\$0
Kingcome *	K6	30.00	\$0
Kitimat	K2	28.00	\$24,480
Kitkatla *	K9	30.00	\$0
Kitsault *	K3	30.00	\$0
Kitwanga	K4	30.00	\$30,763
Kootenay Bay/Riondel *	K5	30.00	\$0
Kyuquot *	K7	30.00	\$0
Ladysmith/ Chemainus **	L4	0.00	\$0
Lake Cowichan **	L5	0.00	\$0
Lillooet	L1	13.97	\$12,220
Logan Lake	L3	8.93	\$7,813
Lumby	L6	0.00	\$0
Lytton	L2	16.07	\$14,056
Mackenzie	M1	24.50	\$21,420
Madeira Park	M5	9.17	\$8,017
Masset	M3	30.00	\$31,375
Mayne Island	M7	10.71	\$9,364
McBride	M2	25.90	\$22,644
Merritt	M4	12.50	\$10,934
Miocene *	M6	23.80	\$0
Nakusp	N1	22.26	\$19,462
Nelson	N5	14.42	\$12,607
New Aiyansh	N2	30.00	\$31,375
New Denver	N3	22.54	\$19,706
Nitinat *	N4	13.65	\$0
Ocean Falls *	CF	30.00	\$0
Oliver/Osoyoos	LS	4.31	\$3,774
Parksville/Qualicum	PQ	6.30	\$5,508
Pemberton	P1	9.77	\$8,548
Pender Island	P8	10.71	\$9,364
Port Alberni	PA	8.82	\$7,711
Port Alice	P2	23.38	\$20,441

Port Clements *	P6	30.00	\$0
Port Hardy	P3	23.38	\$20,441
Port McNeill	P4	23.10	\$20,196
Port Simpson *	P9	30.00	\$0
Powell River	PR	7.35	\$6,426
Prince George	PG	12.60	\$11,016
Prince Rupert	P5	24.50	\$21,420
Princeton	P7	14.18	\$12,403
Quadra Island	Q1	9.77	\$8,548
Queen Charlotte	Q2	30.00	\$31,375
Quesnel	Q3	19.04	\$16,646
Revelstoke	R1	17.50	\$15,300
Rivers Inlet *	R3	30.00	\$0
Salmo	S5	14.42	\$12,607
Salmon Arm/Sicamous	SA	12.04	\$10,526
Saltspring Island	SS	7.63	\$6,671
Saturna Island	S7	10.71	\$9,364
Sayward	S1	16.49	\$14,423
Sechelt/Gibsons	SG	7.28	\$6,365
Slocan Park	S8	7.42	\$6,487
Smithers	S2	24.50	\$21,420
Sointula *	S6	30.00	\$0
Sooke **	SK	0.00	\$0
Sorrento	S9	11.76	\$10,282
Sparwood	S3	18.90	\$16,524
Spences Bridge *	SB	22.65	\$0
Squamish	SQ	4.20	\$3,672
Stewart	S4	30.00	\$31,375
Summerland **	SU	0.00	\$0
Tahsis	T2	16.91	\$14,790
Telegraph Creek *	TC	30.00	\$0
Terrace	T3	19.60	\$17,136
Texada Island	T1	12.92	\$11,302
Tofino	T4	16.28	\$14,239
Trail	TR	11.34	\$9,914
Tumbler Ridge	T5	27.58	\$24,113
Ucluelet	U1	16.28	\$14,239
Valemount	V2	25.34	\$22,154
Vanderhoof	V1	22.26	\$19,462
Waglisla	W4	27.30	\$23,868
Wardner *	W5	23.00	\$0
Whistler	W6	8.51	\$7,446
Williams Lake	W7	12.88	\$11,261
Winlaw *	W3	20.60	\$0
Woss *	W1	24.15	\$0
Zeballos *	Z1	24.45	\$0

Updated: March 6, 2003



Update to the Medical Services Commission Payment Schedule

Preamble

The following modification has been approved by the Medical Services Commission, effective immediately:

Amendment - Section B.16.2.(6)(a)

(6) Epilation of Hair

(a) Face

- This procedure, when done for alteration of appearance is a benefit of MSP when rendered by physicians and only for those patients with documented endocrine abnormality, drug-induced hirsutism or from hair-bearing facial graft.
- MSP authorization is required

Emergency Medicine

Amendment

The following amendment modifies the wording of the Emergency Medicine Preamble as indicated:

Emergency Medical Consultations

- 4) a. A specialist emergency medicine consultation (fee item **01810**) only applies to the Royal College Certified emergency physicians. Other full-time emergency physicians may bill a general practice consultation (fee item **12110, 00110, 16110, 17110 or 18110**) where indicated.
- b. An emergency medicine consultation (whether billed as **01810, 12110, 00110, 16110, 17110 or 18110**) applies only when a patient is referred by another physician (other than an emergency physician at the same institution) who has seen and examined the patient and, because of the complexity, obscurity or seriousness of the problem, the referring physician has requested a consultation.

Ophthalmology

Amendment

The cancellation date of the following provisional item has been extended. This Minute will expire on March 31, 2004 or when replaced by a subsequent Minute whichever occurs first:

P22125	Photodynamic therapy for age-related wet macular degeneration – professional fee	\$274.39
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Notes:

- i) Payable to Retinal Physicians only.
- ii) This service is restricted to the Vancouver/Richmond Health Authority (The Eye Care Centre at Vancouver General Hospital) and the Capital Health Region.

Psychiatry

In accordance with Section 26(3) of the *Medicare Protection Act*, the following modifications to the Payment Schedule have been approved by the Medical Services Commission, effective as indicated.

DELETION:

Effective March 31, 2003, the following clause is hereby deleted from the Medical Services Commission Psychiatry Fee Schedule Preamble:

Geographic Payment Rates

Differential payment rates for all Psychiatry fee items are determined on the basis of the geographic location where the service is provided as follows:

1. *Well-served areas* are those with relatively high psychiatrist-to-population ratios, eg., Greater Vancouver and Victoria. Payment rate is 100% of stated fee.
2. *Poorly-served areas* are those with very low psychiatrist-to-population ratios and quality of life is unattractive to most psychiatrists, with very limited recruitment prospects without special incentives. Payment rate is up to 121% of stated fee, depending on location.
3. *Intermediate areas* are those not designated as well-served or poorly-served. Payment rate is 101% of the stated fee.

Exact designation of geographic areas and payment rates is determined by the BC Psychiatric Association. Payment rate is determined by location of service, rather than residence of patient or psychiatrist.

The claim should specify the community where the service is provided, with an entry in the service clarification code field. If no entry is made in this field, 100% of the stated fee will be paid.

The cost of premium payments will not include the NIA payments which would have been payable for particular communities in the poorly served areas.

AMENDMENT:

Effective April 1, 2003, the Psychiatry fees are amended as indicated:

00605	Emergency visit	\$123.60
00607	Office visit	\$39.75
00608	Hospital visit	\$46.62
00609	Home visit	\$61.88
00610	Consultation - private office or hospital out-patient	\$185.95
00613	Geriatric consultation	\$256.46
00614	Repeat geriatric consultation	\$128.21
00615	Consultation - hospital/institution in-patient or home	\$204.54
00622	Consultation - emotionally disturbed child	\$320.65
00623	Consultation - emotionally disturbed family	\$320.65
00624	Evaluation interview with family member	\$72.99
00625	Repeat consultation - individual	\$93.91
00626	Repeat consultation - emotionally disturbed child	\$160.33
00627	Repeat consultation - emotionally disturbed family	\$160.33

Psychotherapy – individual (office or hospital out-patient):		
00630	- per ½ hour	\$79.46
00631	- per ¼ hour	\$110.74
00632	- per 1 hour	\$141.81

Psychotherapy – family/conjoint therapy – (two or more family members)		
00633	- per ½ hour	\$84.68
00635	- per ¼ hour	\$118.01
00636	- per 1 hour	\$151.19
00641	Electroconvulsive therapy.....	\$70.66
00645	Patient management conference – per ¼ hour	\$39.75

Psychotherapy – individual (hospital or in-patient or home)		
00650	- per ½ hour	\$93.26
00651	- per ¼ hour	\$129.98
00652	- per 1 hour	\$166.56

Group psychotherapy - fee per patient, per ½ hour:		
00663	- three patients	\$27.09
00664	- four patients	\$21.90
00665	- five patients.....	\$18.80
00666	- six patients	\$16.74
00667	- seven patients.....	\$15.26
00668	- eight patients.....	\$14.16
00669	- nine patients.....	\$13.29
00670	- ten patients	\$12.59

Plastic Surgery

Amendment

The following items are effective on a temporary basis from December 15, 2002 until June 30, 2005. On June 30, 2005 and after review by the British Columbia Medical Association, a recommendation may be made to remove the temporary status:

T06203	Tendon transfer in hand and wrist	\$439.16 Anaes.Level 2
T06024	- each additional, to a maximum of three (extra)	\$131.73 Anaes.Level 2

Deletion

The following listing is deleted, effective December 14, 2002:

06191	Tendon transfer, Transplant – each additional (extra)
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Vascular Surgery

The following item has been approved on a provisional basis. This will expire on June 30, 2003, or when replaced by a subsequent Minute, whichever occurs first.

P77177	Abdominal aortic aneurysm repair using endovascular stent graft – Vascular surgery component	\$1056.08 Anaes.Level 9
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Laboratory Medicine

The following modifications to the Payment Schedule have been approved by the Medical Services Commission, effective December 15, 2002.

Amendment

The notes subsequent to the following fee items are modified as indicated:

P90127*** Factor V Leiden / PGM – 1st gene

Notes:

- i) Restricted to Royal Columbian, Vancouver and Victoria General Hospitals.
- ii) Not billable for screening purposes.
- iii) Applicable to patients with thrombophilia.

P90128*** Factor V / PGM – 2nd gene

Notes:

- i) Billable only when performed with P90127.
- ii) Restricted to Royal Columbian, Vancouver and Victoria General Hospitals.

The following modifications to the Payment Schedule have been approved by the Medical Services Commission effective immediately:

1. The following Protocol for Allergen specific IgE is hereby added to the Preamble to the Laboratory Medicine Payment Schedule following the Lipid Testing Heading.

CHEMISTRY GUIDELINES:

Protocol for Allergen Specific IgE (91075)

- 1 The gold standard for establishing the presence of allergen specific IgE antibodies is the skin prick test (SPT).
- 2 The approved indications for allergen specific IgE antibodies are:
 - History of life threatening or severe allergic reaction
 - Presence of generalized skin disease

2. The following notes subsequent to fee item 91075 are hereby deleted:

Notes:

1. The criteria for ordering fee item 91075 is to be reserved for patients with:
2. Debilitating symptoms unresponsive to usual management.
3. A history of life threatening severe reactions where greater effort is needed to identify the specific allergen.
4. Generalized skin diseases of patients for whom skin tests cannot be done.

3. The following notes are hereby added to fee item 91075:

Notes:

- i) The performing laboratory must document that the patient meets the approved indications and supply that information as a billing note record.
- ii) The standard number of allowable allergen specific IgE antibodies per 12 month period is 5 per patient.

- iii) This number can be increased to 10 when further approved by a laboratory physician. (This will require the addition of the billing number of the approving laboratory physician to the note record)
- iv) If the ordering physician is an allergy specialist (as approved by the Section of Clinical Immunology and Allergy) the number of allowable tests per 12 month period can exceed the allowable number specified in 2 or 3, up to 20. A note record is required beyond 20.

(See the Protocol under the Chemistry Guidelines in the Laboratory Medicine Preamble)

Amendment

The cancellation date of the following provisional item has been extended – it will expire on March 31, 2004 or when replaced by a subsequent Minute, whichever occurs first.

P91760***	Helicobacter pylori Carbon 13 urea breath test	\$59.99
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Amendment

The cancellation date of the following provisional item has been extended. This Minute will expire on March 31, 2004 or when replaced by a subsequent Minute, whichever occurs first:

P92355	Troponin	\$30.77
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Amendment

The cancellation dates of the following provisional items have been extended. This Minute will expire on June 30, 2003 or when replaced by a subsequent Minute, whichever occurs first:

Drugs of Abuse Testing – Screening Assays:

P92510	Methadone Metabolite	\$4.33
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P92513	Methadone	\$4.33
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Drugs of Abuse – Confirmatory and Specific Quantitative Assay Testing

P92515*	Blood Methadone	\$56.73
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Nuclear Medicine

Amendment

The cancellation date of the following provisional item has been extended – it will expire on March 31, 2004 or when replaced by a subsequent Minute, whichever occurs first.

P95012	Helicobacter pylori Carbon 14 urea breath test	\$104.14
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MSP BULLETIN

SPRING 2003

The Medical Services Plan's Bulletin is provided to help physicians identify patients whose MSP benefits have payment restrictions. This Bulletin provides important billing information for physicians only. Thank you for respecting the confidential nature of this information.

The Bulletin is an updated listing of restricted MSP enrollment numbers for clients who have signed a legal *Agreement of Limitation* form which limits MSP payment responsibilities to one primary care physician. If care is provided by other physicians, the charges must be made directly to the clients. MSP will not accept payment responsibility unless special circumstances are clearly stated. An example of this would be medical care that has been provided by an emergency physician in the hospital emergency room.

MSP is concerned about the potential misuse of CareCards and strongly recommends a complete check of CareCard information at all first appointments. If you suspect any unusual use of a CareCard, please request a second piece of picture identification in order to verify that the CareCard is being presented by the person named on the card.

PHN	Birthdate (MM/YY)	Sex M/F	Physician Number
9013676868	12/54	M	06541
9023967395	02/54	F	03023
9025293026	12/58	M	24287
9029287062	06/52	F	06061
9029345046	05/43	F	06541
9029596344	09/55	M	00792
9030165823	12/54	F	05334
9030205973	05/54	M	26411
9030780581	05/29	F	08241
9030861738	10/45	M	01604
9032398914	08/56	M	09760
9032842679	05/59	F	01229
9034248181	10/59	F	07384
9034793801	06/59	F	06468
9035162781	06/34	F	01454
9035294522	07/58	M	23759
9041726364	07/56	F	03733
9071584167	06/48	M	09604
9089058947	11/61	F	03462
9104870848	04/67	F	09443
9107346403	08/54	M	08365



Fair PharmaCare

The major PharmaCare plans - the universal plan and the seniors' plan - are being combined into one new plan. The new plan assists families to pay for eligible prescription drugs based on their net income. This means the lower a family's income, the more assistance the government will provide towards their prescription drug costs.

How to Register for Fair PharmaCare

The new Fair PharmaCare program became effective May 1, 2003. All residents of British Columbia should register for Fair PharmaCare regardless of your income - you should register in order to receive your maximum PharmaCare financial assistance. If you have not registered prior to May 1, 2003 you can continue to register at any time. To register immediately use either the on-line or telephone registration - you can also send your registration by mail or fax.

By Phone:

Call the Registration Desk at 1 800 387-4977 and provide the required information to register. If you register by phone you have the option of entering your information using the automated system or waiting for assistance and speaking to a representative. This is the quickest way to register.

Through the Internet:

Visit the Fair PharmaCare web site to register at <http://www.healthservices.gov.bc.ca/pharme/>

By Mail:

Applications are available at any pharmacy. It takes 6-8 weeks for your mail-in registration to be processed.

What You Need to Register

To register your family for Fair PharmaCare you need:

- BC CareCard numbers for you, your spouse (if applicable) and dependent children (if applicable)
- 2001 Net family income for you and your spouse (if applicable)
- Social Insurance numbers for you and your spouse (if applicable)
- Birthdates for you, your spouse (if applicable) and your dependent children (if applicable)

Register Anytime!

Approximately 900,000 BC residents are now registered. It is important for all BC residents to register for Fair PharmaCare - although the program became effective May 1, 2003 you can still register at any time.

